Center for Psychology and Counseling

Chart #_____

118 E. Sunbridge Drive, Fayetteville, AR 72703

(479) 444-1400

Patient Name _____ DOB _____ Sex ____Today's Date _____

SS# _____ Marital Status (circle one): Single / Married / Divorced / Separated / Widowed

Allergies _____ Responsible Party _____

Address _____ City _____ State _____ ZIP _____

Primary Phone _____ (Home) (Cell) (Work) Alternate Phone _____ (Home) (Cell) (Work)

Email address _____

**********Please complete this section if the patient is a minor**********

Parent/Guardian's Name _____ DOB _____ SS# _____

Employer _____ Work Phone _____

Parent/Guardian's Name _____ DOB _____ SS# _____

Employer _____ Work Phone _____

**********Insurance Company Information**********

Primary Company

Company_____ ID# _____ GP# _____ Phone # _____

Policyholder's Name _____ Policyholder's DOB: _____

Secondary

Company _____ ID# _____ GP# _____ Phone # _____

Policyholder's Name _____ Policyholder's DOB: _____

********** Emergency Information**********

Name _____ Phone _____

Relationship to Patient _____

ACKNOWLEDGEMENT OF PAYMENT

All professional services rendered are charged to the patient. The necessary forms will be provided to insure your prompt reimbursement by your insurance carrier. The guardian is responsible for all fees, deductibles, and co-payments required by your insurance carrier. Payment is due in full the day services are rendered unless we have a participating agreement with your insurance carrier or other arrangements have been made with us.

_____

Initials

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION & INSURANCE ASSIGNMENT

I hereby authorize the Center for Psychology and Counseling to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the clinician(s) all payments for psychological services rendered. I understand that I am responsible for any amount not covered by insurance.

_____

Initials

Signed_____

Date _____

CENTER FOR PSYCHOLOGY AND COUNSELING

Consent to Treat and Professional Disclosure

Consent

I hereby give my consent for me (or my child) to receive psychological services from the Center for Psychology and Counseling. I understand that I am free to terminate services at any time.

Confidentiality

I understand that the information I provide is confidential and, in general, will be released to others only by my written consent (or the written consent of the custodial parent in the case of a minor child). Mental health providers are mandated by law to report when a person is (1) an imminent danger to himself/herself or to others, (2) and instances of abuse. Courts, legal proceeding, insurance and billing services may also require information within the normal limits of standard practice. All of our providers are licensed in their respective areas of expertise and adhere to their professional code of ethics.

Contact Emergency

I understand that most questions and concerns will be addressed in session. In the event of an emergency, I should call 911 or proceed to a hospital emergency room.

_____	_____
Print Name of Patient	Signature of Patient or Parent/Guardian (if client is a minor child)

Thomas T. Lawson, PhD

Amy Partak, L.C.S.W. Carla Brown, L.C.S.W

Holly Lynch, L.P.C. Joel Gray, L.P.C

Kristen Speer, L.P.C. Roxanne Ross, L.P.C.

Stefanie Lawson, L.P.C.

Please read all of the following and initial to show acknowledgement of our policies.

The Center for Psychology & Counseling requires at least a 24-hour notice for cancellation of all appointments. If you do not keep an appointment, and do not cancel within the specified time, you deprive other patients of an appointment time. Therefore, if you do not keep your new patient appointment you will be charged a **$100** deposit to be paid in full before scheduling another appointment. This deposit will be applied to any future costs that are patient responsibility. Follow up appointments that are not cancelled within the 24 hours or that you do not show for will be considered a missed appointment and you will be charged a fee of **$75**. Please understand that insurance companies do not pay for missed appointment fees.

_____
Initials

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Any psychological testing that accompanies treatment at The Center for Psychology and Counseling is an additional fee not included with the diagnostic interview or the follow-up appointment to review the test results. These charges will be billed to your insurance, but may not be covered.

I understand it is my responsibility to pay any amount not covered by my insurance policy.

_____
Initials

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MINORS: The adult accompanying a minor is responsible for full payment. This is regardless of any divorce decrees (which is a contract between parents; not between you and your therapist). If the ex-spouse is responsible for a minor's bill, the adult accompanying the minor is responsible for paying the therapist's fees and may collect reimbursement from the ex-spouse. Parents are responsible for sending co-payments for unaccompanied minors at each visit.

_____
Initials

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Legal Proceedings: If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all professional time involved, including preparation and transportation costs, even if they are called to testify by another party. Payment for these services will be due in full prior to services being rendered. Insurance companies will not pay for involvement in a legal proceeding.

_____
Initials

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Please be advised that a $20 fee will be charged for all returned checks.

_____
Initials

Signed_____
Date _____

Center for Psychology & Counseling

118 E. Sunbridge Dr. | Fayetteville, AR 72704 | P. 479.444.1400 F. 479.444.1422 | terrylawson.com

Psychologist
Thomas T. Lawson, Ph.D.

Licensed Social Worker
Amy Partak, L.C.S.W.
Carla Brown, L.C.S.W.

Licensed Counselor
Holly Lynch, L.P.C.
Joel Gray, L.P.C.
Kristen Speer, L.P.C.
Roxanne Ross, L.P.C.
Stefanie Lawson, L.P.C.

Life Coach
Jennifer Lawson, Ed.D.

AUTHORIZATION TO INDIVIDUALS

This release authorizes our clinicians and staff to communicate with individuals such as family members. Due to HIPAA regulations, if their name is not listed below we are unable to speak with them.

I give all therapists and professional staff associated with **Center for Psychology & Counseling** permission to disclose the private health information set forth below to the following people at the request of one or more of these individuals.

The specific information these persons may receive is as follows:

_____
_____
_____

Name (Please print): **Relationship**

_____
_____
_____

I understand that **Center for Psychology & Counseling** will not release any information to any person(s) not listed above.

In addition, I understand or acknowledge that I have the right to revoke this authorization at any time by giving **Center for Psychology & Counseling** a written notice. I understand that this release will expire one (1) year from the date below unless written notice is given.

Patient Name_____ DOB_____
(Please Print)

_____ _____
Signature Date

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name and relationship to the patient.

_____/_____

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AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION TO/FROM PROFESSIONALS
(I.E., PHYSICIANS, ATTORNEYS, ETC.)

I hereby request that my Private Health Information be released to / obtained from:

_____
Facility/ Physician

_____
Address

_____
City State Zip

_____
Phone Fax

Specific information to be released to / obtained from the above referenced entity:

_____
_____
_____

I understand that I have the right to revoke this Authorization in writing at any time and that I may do so by issuing a revocation in writing to the Clinic. I understand that this release will expire one (1) year from the date below unless written notice is given.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the receiving entity and may no longer be protected by the Privacy Standards of this Clinic.

The Clinic has informed me that the Clinic will not condition treatment, payment, enrollment, or eligibility for benefits on obtaining this authorization.

I understand that I may refuse to sign this Authorization.

Patient Name_____ DOB_____
(Please Print)

_____ _____
Signature Date

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name and relationship to the patient.

_____/_____

Center for Psychology and Counseling

A copy of the HIPAA Notice of Privacy Practices is available upon request. Please ask the receptionist for a copy if you would like one for your records.

I, _____, verify that **Center for Psychology & Counseling** has made a copy of the Notice of Privacy Practices available to me.

_____ _____

Signature Date

****

I give **The Center for Psychology & Counseling** permission to leave message(s) on my answering machine if they should need to remind me of an appointment, change an appointment, etc…and are unable to reach me in any other way.

_____Yes _____No